Patient Name: _____ **DOB**:_____

Date of last eye exam: _____ **Reason for your visit**: _____

Have you ever been diagnosed with the following eye conditions?

☐ Cataracts ☐ Glaucoma ☐ Migraines ☐ Blindness
☐ Macular Degeneration ☐ Dry Eyes ☐ Crossed/Lazy Eye ☐ Retinal Detachment
☐ Other, please specify: _____

Prior eye surgeries (please circle which eye(s)):

☐ Cataract Surgery Right / Left / Both ☐ LASIK Right / Left / Both
☐ Other, please specify: _____

Have you ever experienced a serious eye injury? If so, explain: _____

Please list any drops or medications used for your eyes: _____

Have you ever been diagnosed with the following medical conditions?

☐ Asthma ☐ Bleeding Disorder ☐ High Cholesterol ☐ Stroke
☐ Arthritis ☐ Heart Disease ☐ Hyperthyroid ☐ Type I Diabetes
☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Hypothyroid ☐ Type II Diabetes
☐ Cancer, please specify: _____
☐ Other, please specify: _____

Please list any major surgeries: _____

Please list all medication allergies: _____

Please list all medications (or attach medication list when you return this paperwork):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Has anyone in your family been diagnosed with the following conditions? Please list familial relationship.

☐ Cataracts: _____ ☐ Crossed/Lazy Eye: _____
☐ Glaucoma: _____ ☐ Diabetes: _____
☐ Macular Degeneration: _____ ☐ Heart Disease: _____
☐ Blindness: _____ ☐ Other, please specify: _____

Do you currently smoke? Yes / No **If so, how much?** _____
Are you a former smoker? Yes / No **If so, when did you quit?** _____
Do you drink alcoholic beverages? Yes / No **If so, how many drinks per week?** _____
Are you pregnant or planning on becoming pregnant? Yes / No
Has there been any change in your weight in the last 6 months? Yes / No Gain / Loss
Occupation? _____

Primary Care Doctor: _____

Preferred pharmacy: _____ **Phone number:** _____